**STATE OF MICHIGAN**

**DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS**

**OFFICE OF FINANCIAL AND INSURANCE REGULATION**

**Before the Commissioner of Financial and Insurance Regulation**

**In the matter of**

**XXXXX**
**Petitioner**

**v** **File No. 122265-001-SF**

**Blue Cross Blue Shield of Michigan**
**Respondent**

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**Issued and entered**
**this _7th___ day of December 2011**
**by R. Kevin Clinton**
**Commissioner**

# ORDER

## I. PROCEDURAL BACKGROUND

On July 11, 2011, XXXXX (Petitioner) filed with the Commissioner of Financial and Insurance Regulation a request for an external review under Public Act No. 495 of 2006, MCL 550.1951 *et seq.* The Commissioner reviewed the request and accepted it on July 18, 2011.

The Petitioner is enrolled for group health care coverage through the State of Michigan, a self-funded government plan under Act 495. The plan is administered by respondent Blue Cross Blue Shield of Michigan (BCBSM). Section 2(2) of Act 495, MCL 550.1952(2), authorizes the Commissioner to conduct this external review as though the Petitioner were a covered person under the Patient's Right to Independent Review Act, MCL 550.1901 *et seq*.

The Commissioner notified BCBSM of the external review and requested the information used in making its adverse determination. The Commissioner received BCBSM's response on July 27, 2011.

The issue in this external review can be decided by a contractual analysis. The Commissioner reviews contractual issues pursuant to MCL 550.1911(7). This matter does not require a medical opinion from an independent review organization.

## II. FACTUAL BACKGROUND

The Petitioner receives health care benefits under the State Health Plan PPO for retirees not eligible for Medicare. His benefits are described in the plan's benefit guide.

On December 6, 2010 and March 2, 2011, the Petitioner received hospital emergency room (ER) care. A $50.00 copayment was applied on both of these visits.

The Petitioner appealed the application of the copayments. A managerial-level conference was held and BCBSM issued a final adverse determination on May 19, 2011, affirming its claims decision.

## III. ISSUE

Is BCBSM required to waive the copayment for the ER care on December 6, 2010 and March 2, 2011?

## IV. ANALYSIS

Petitioner's Argument

The Petitioner acknowledges that there is a requirement in the benefit guide for a $50.00 copayment for ER services which is waived if the visit is followed by a hospital admission. He states BCBSM was wrong to apply the copayment for the ER visits on December 6, 2010 and March 2, 2011, because he was admitted on both dates. He indicates in his request for external review:

> The emergency doctors in both instance admitted me. They determined that because of my condition I needed to be admitted. All Healthcare staff I came in contact with indicated I was being admitted. I was required to sign discharge papers. Page 27 of the Benefit Guide does not define admission or more importantly, its applicability. The application as such is erroneous and arbitrary at best. A hospital administrator informed me the insurance company required the hospital submit the billing as outpatient. In both cases physicians determined admission was necessary. . . .
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> When I was sent home after emergency treatment for the same medical issue I had no problem paying the deductible. In the two instances I am appealing I was not. Therefore I should be reimbursed. . . .

The Petitioner believes the application of the $50.00 copayments is erroneous and arbitrary at best.

BCBSM's Argument

It is BCBSM's position that the claims for the ER visits on December 6, 2010 and March 2, 2011, were correctly processed. BCBSM indicates that all of the documents received for the claims show that the services were rendered on an outpatient basis and there was no hospital admission which would allow the emergency room copayment to be waived. BCBSM also stated:

> In this appeal [the Petitioner] appears to argue that he was admitted and that the hospital personnel informed him that the insurance companies require the hospital to bill these procedures as outpatient. However, without more information this assertion cannot be confirmed. Therefore, the issue is if BCBSM processed the claims in question in compliance with the terms of [the Petitioner's] coverage based on the hospital's billing. In his letter with this appeal [the Petitioner] acknowledges that BCBSM was billed for outpatient services. BCBSM's records categorize the services in question as outpatient. As such, based on the language of coverage, the copayments were appropriate.

BCBSM states it processed the claims according to the way the hospital billed them. As such, based on the language of coverage, the copayments were appropriate.

Commissioner's Review

The Petitioner indicates he was admitted to the hospital on December 6, 2010 and March 2, 2011. However, there was no documentation provided that established that the Petitioner was admitted to the hospital on either date.

It is possible that the Petitioner was admitted for "observation," a status where he would be kept for less than a 24-hour stay. The emergency room report from December indicates that his patient type was "observation" and the history and physical report from the March visit indicates that his "Room #" was "OBS." Observation is considered to be and is paid as outpatient hospital services.

It is undisputed that the claims were submitted as outpatient services. Therefore, the Commissioner concludes that BCBSM correctly processed those claims and applied the $50.00 ER copayments according to the terms of the benefit guide.

## V. ORDER

Blue Cross Blue Shield of Michigan's final adverse determination of May 19, 2011, is upheld. BCBSM is not required to waive the Petitioner's emergency room copayments.

This is a final decision of an administrative agency. Under MCL 550.1915, any person aggrieved by this Order may seek judicial review no later than 60 days from the date of this Order in the circuit court for the county where the covered person resides or in the circuit court of Ingham County. A copy of the petition for judicial review should be sent to the Commissioner of Financial and Insurance Regulation, Health Plans Division, P.O. Box 30220, Lansing, MI 48909-7720.

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R. Kevin Clinton
Commissioner